

Camp Weekaneatit

2009 Summer Camp Application

Please, complete the application in its entirety to help us best prepare for your child to attend camp!

Sorry, but health forms received without a doctor/pnp signature will be considered incomplete and returned to you.

Dear Parents and Campers:

We are getting excited about **Camp Weekaneatit's** First summer camp for children and teenagers with celiac disease! We expect to have about 50 campers join us for the week of July 26-31, 2009. Summer camp is designed for children ages 8 to 17.

Applications for campers are accepted on a first come, first serve basis. Please return all original paperwork to us by June 15, 2009.

- ⇒ **You can mail the application to Camp Weekaneatit to hold a spot, but you must schedule an appointment with a pediatrician, health department or gastroenterologists and send the medical form to us by June 15. It is an American Camping Association requirement and Camp Twin Lakes policy that all children must have a medical provider's signature before participating in camp.**

Our 2009 session will be held at Camp Will-A-Way in Winder, Georgia. Camp Weekaneatit is a partner of Camp Twin Lakes.

We will have a medical staff available 24 hours a day to care for your child's special medical needs. Our camp staff consists of volunteers from the celiac community and many other talented and caring people from the community. Our camper to staff ratio is 3:1 and our minimum age for volunteer counselors is 18. Our Menu for the week is gluten free, and we will provide snacks and treats everyday! **Camp Weekaneatit will be the only camp in residence during our week and only GF foods will be prepared.**

Campers sleep in cabins with about 8-10 other campers of their age and 3 to 4 adult cabin counselors. Our day starts with breakfast and ends with an evening program. We have a dance, games, pool parties and a talent show during the week!

The cabins are air conditioned with twin beds for each person. . For more about the activities – see **“What do we do at Camp Weekaneatit???”**

- ⇒ Applications received without a doctor's signature (on page 8 of the application) will be considered incomplete and returned to you.
- ⇒ After receiving your completed application, a confirmation letter with more information will be mailed to you in June.
- ⇒ The earlier we receive camper applications, the better we can plan for the week of camp.

We realize you may have many questions about sending your child to summer camp. Feel free to call us anytime. Email Susan Wagner with Questions: SWagner@dixon-hughes.com.

PLEASE RETURN APPLICATION TO...

**CAMP Weekaneatit
CCDHC
Attn: Myra Atkinson
Northside Professional Center
993D Johnson Ferry Rd.
Suite 440
Atlanta, GA 30342**

We look forward to seeing your child or teenager on the first day of Camp Weekaneatit on July 26, 2009!!! (For your planning purposes, Drop-off time is between 2:00 PM and 4:00 PM on July 26, and Pick up is between 2:00 PM and 4:00 PM on Friday July 31, 2009.)

**Camp Address:
Camp Will-a-Way
210 S. Broad Street
Unit 5
Winder, GA 30680
(Please do not send any correspondence to this address.)**



What do we do at Camp Weekaneatit?????

Everything!!!



SWIMMING - We have a great pool!

BOATING, CANOES, KAYAKS, & PADDLE BOATS - We have many types of boats and .ke for boating.



SPORTS AND GAMES - On the field we play games of softball, volleyball, kickball, t ball and soccer.

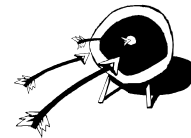
DRUMMING - Learn to drum the beat on real African drums!

ARTS & CRAFTS - There will be a wealth of wonderful, creative projects that you can take home after camp.

ROPES COURSE and ZIP LINE - This high challenge and exciting course and zip line are available for teens in camp.

CLIMBING WALL - See if you can climb like Spider Man on the climbing wall!

ARCHERY - Learn to hit the target on the archery range.



FISHING - You should see all those fish!!!



BIKING - Mountain bike riding.

NATURE -Observe native critters in their habitat.

EAT!! - The whole menu will be gluten-free, so no worries about what you can or cannot eat!

2009 CAMP WEEKANEATIT CAMPER APPLICATION

July 26 – July 31, 2009 for 8*-17 year olds with Celiac Disease (*By September 1, 2009)

Return applications to: **CAMP Weekaneatit, CCDHC, Attn: Myra Atkinson, 993D Johnson Ferry Rd., Suite 440, Atlanta, GA 30342**

Circle Camper's T-shirt size: Adult S M L XL XXL Child S M L

GENERAL INFORMATION (*Please include a photograph of your child with this application.)

Child's Name _____

Preferred name for nametag: _____ Birth date _____ Sex _____

Address _____ City _____

State _____ Zip _____ County _____ Camper Home Phone _____

Camper E-Mail Address _____ Age at camp _____ *Current* grade in school _____

Diagnosis _____ Date of Diagnosis _____

To assist us with cabin assignments, please describe any special equipment or other unique needs for your child: i.e. walker, wheelchair, sight/hearing loss, other assistance:

Parent Name/Guardian with whom child lives _____ Relationship to child _____

Parent/Guardian Preferred E-mail _____ Parent/Guardian Secondary E-mail _____

Home Phone _____ Work Phone _____ Cell Phone _____

May Camp Weekaneatit contact you and send correspondence though **e-mail**? Y N

If child does not live with both parents, please list other parent (or guardian) below.

Parent Name _____ Relationship to child _____ Home Phone _____

Work Phone _____ Cell Phone _____ Address _____

Please note if you **DO NOT** want your child's name & contact information in our Camper/Counselor Directory? _____

EMERGENCY CONTACT – Person to contact in case of an emergency if parents cannot be reached:

Name _____ Cell Phone _____

Relationship to child _____ Home Phone _____

Name of insurance company (Please include copy of card): _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy No: _____ Medicaid Number: _____

Camp Fee is \$250 per camper. Please make check to Camp Twin Lakes.

If you would like to be considered for a limited number of scholarships, please attach an explanation of need.

Applicants will be accepted on a first come first served basis and are subject to review by the Medical Committee.

Applications are due June 15, 2009

SPECIAL NEEDS

Does your child use any special equipment such as a walker, crutches, wheelchair or prosthesis?

Please list any physical restrictions or activity limitations (i.e. no swimming, no prolonged sun exposure, no competitive sports, sight or hearing loss, has difficulty walking distances, requires assistance to dress or eat).

Is there anything we should know about your child that will make his/her adjustment smoother?

Is your child able to function at his or her age level? Please describe.

Describe any bedtime or sleep habits. (ex. sleeps with parent, toys, talks/walks in sleep, etc.):

Does your child have any serious fears? Please describe.

Please indicate any further information about your child's **medical** and/or **emotional** needs that you feel we should know (sees a psychiatrist or psychologist regularly, etc).

If possible, what other camper(s) would your child like to be in a cabin with?

CAMP TWIN LAKES, INC.

RELEASE, WAIVER, INDEMNIFICATION, AND HEALTH AFFIRMATION

By signing this Release, Waiver, Indemnification, And Heath Affirmation below, I intend to be legally bound hereby, for myself, my minor children, my wards, my heirs, executors, administrators, successors, and assigns, and in consideration of Camp Twin Lakes, Inc.'s ("CTL") permitting me or my child to attend and participate in activities at CTL's facility ("Camp Will-A-Way"), I hereby release and forever discharge CTL and any of its officers, directors, employees, and agents from and against any and all damages of any kind whatsoever arising out of any injury, illness, infirmity, disease, or loss of any kind, personal or property, to me or my child during or related to me or my child's attendance at a camp at Camp Will-A-Way. I understand and certify that me or my child's participation in _Camp Weekaneatit ("Partnering Organization") and its activities at Camp Will-A-Way is completely voluntary and I have familiarized myself with Partnering Organization's program and activities at Camp Will-A-Way in which I/my child/my ward will be participating. I recognize that certain hazards and dangers are inherent in Partnering Organization's activities and programs, and I acknowledge that CTL cannot ensure or guarantee that the participants, equipment, premises and/or activities will be free of hazards, accidents and/or injuries. I further recognize and have instructed me or my child, to the extent my child will be attending and participating in activities at Camp Will-A-Way, in the importance of knowing and abiding by the rules, regulations, and procedures for Partnering Organization's camp at Camp Will-A-Way. I also agree to defend, indemnify and hold CTL and its officers, directors, employees, and agents harmless from and against any and all damages, costs, claims, demands, actions or causes of action sustained by any other person as a result of me or my child's participation at Camp Will-A-Way, whether caused in whole or in part by the negligence of CTL, its officers, directors, employees or agents; provided, however, that this provision shall not operate to require indemnification to the extent such loss, cost, claim, damage, or expense is caused by the gross negligence or willful misconduct of CTL. Further, I attest that my health insurance will cover any medical and hospital expenses that me or my child incur and that I have received approval from a doctor authorizing me or my child to participate in the activities at Camp Will-A-Way. I further agree to inform Partnering Organization of any activities in which me or my child is not to participate.

I have read and hereby accept the conditions described above. As an adult applicant, or the legal guardian of a minor applicant, I also give permission for myself (or the minor child or ward) to be treated by a doctor if needed.

Adult Signature: _____ **Date:** _____

CAMP TWIN LAKES, INC.

RELEASE AND WAIVER OF COPYRIGHT AND OTHER USAGE RIGHTS

By signing this Release And Waiver Of Copyright And Other Usage Rights below, I intend to be legally bound thereby, for myself, my minor children, my wards, my heirs, executors, administrators, successors, and assigns, acknowledging that Camp Twin Lakes, Inc., ("CTL") has the right to photograph, videotape, and/or create other audio-visual materials of me or my child's participation in activities of CTL's facility (collectively, the "Audio-Visual Materials") and that CTL has the royalty-free right to use the Audio-Visual Materials of me/my child/my ward in public relations, marketing and promotional activities and materials in any medium whatsoever including, but not limited to, videotapes, pamphlets, and brochures including use in print, radio, television and the internet. I further acknowledge that CTL shall have all rights of copyright in and to such Audio-Visual Materials and may exploit such copyright fully. I release and waive all rights and interests in and to such Audio-Visual Materials.

I have read and hereby accept the conditions described above. As an adult applicant, or the legal guardian of a minor applicant, I also give permission for myself (or the minor child or ward).

Adult signature: _____ Date: _____

Name of Minor Child: _____

Camper Health Form – 2009

Required by all campers by June 15 –Camp Weekaneatit will not be able to get this form completed for you. You must obtain a doctor/pnp signature on page 7. You will receive a Late Change form with your confirmation in June for any changes prior to camp. So that the camp can be aware of all your child's needs, provide complete information.

Name _____ Birth Date _____ Age at Camp _____
first middle last

Diagnosis _____ Date of Diagnosis _____

Home Phone _____ Social Security Number _____ Gender *Male Female*

Custodial Parent/Guardian _____
name relationship

Work Phone _____ Cell Phone _____

Work Phone _____ Cell Phone _____

Name of Gastro _____ Phone _____

Address _____

Name of Pediatrician _____ Phone _____

Address _____

Allergies - List all known.

Medication Allergies	Describe reaction and management of the reaction
_____	_____
_____	_____

Food Allergies	
_____	_____
_____	_____

Other Allergies – Include insect stings, hay fever, asthma, etc.	
_____	_____
_____	_____

Dietary Restrictions (circle one): **GF Only**

Vegetarian: **yes no**

_____ Other (describe) _____

General Questions (Explain “yes” answers in the space provided to the side of each question.)

Has your child / Does your child:

- | | | | |
|---|---|---|-------|
| 1. Had any recent injury or infectious disease? | Y | N | _____ |
| 2. Have a chronic or recurring illness/condition other than celiac? | Y | N | _____ |
| 3. Been hospitalized in the last 18 months? | Y | N | _____ |
| 4. Had surgery in the last 18 months? | Y | N | _____ |
| 5. Have frequent headaches? | Y | N | _____ |
| 6. Ever had a head injury? | Y | N | _____ |
| 7. Ever been knocked unconscious | Y | N | _____ |
| 8. Wear glasses, contacts or protective eye wear? | Y | N | _____ |
| 9. Ever passed out during or after exercise? | Y | N | _____ |
| 10. Ever been dizzy during or after exercise? | Y | N | _____ |
| 11. Ever had seizures? | Y | N | _____ |
| 12. Ever had chest pain during or after exercise? | Y | N | _____ |
| 13. Ever had frequent ear infections? | Y | N | _____ |
| 14. Have an orthodontic appliance? | Y | N | _____ |
| 15. Have a history of bed wetting? | Y | N | _____ |
| 16. Ever had high blood pressure | Y | N | _____ |
| 17. Ever been diagnosed with a heart murmur? | Y | N | _____ |
| 18. Ever had back problems? | Y | N | _____ |
| 19. Ever had problems with joints (knees, ankles)? | Y | N | _____ |
| 20. Have any skin problems (itching, rash, acne)? | Y | N | _____ |
| 21. Have diabetes? | Y | N | _____ |
| 22. Have asthma? | Y | N | _____ |
| 23. Had mononucleosis in the past 12 months? | Y | N | _____ |
| 24. Had problems with diarrhea/constipation? | Y | N | _____ |
| 25. Have problems sleepwalking? | Y | N | _____ |
| 26. If female, begun menstrual cycle? | Y | N | _____ |
| 27. Ever had an eating disorder? | Y | N | _____ |
| 28. Have ADD/ADHD? | Y | N | _____ |

Which of the following has your child had?

Please give dates of immunizations

	Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
___ Measles							
___ Chicken Pox	DTP/DTaP	___	___	___	___	___	___
___ German Measles	DT/Td	___	___	___	___	___	___
___ Mumps	Tetanus	___	___	___	___	___	___
___ Hepatitis A	Polio	___	___	___	___	___	___
___ Hepatitis B	Hep. B	___	___	___	___	___	___
___ Hepatitis C	Hib	___	___	___	___	___	___
	MMR	___	___				
	Measles	___	___				
TB Mantoux Test:	Mumps	___	___				
Date: _____	Rubella	___	___				
Result: Positive Negative	Varicella	___	___				

PLEASE NOTE: If your child has been exposed to any communicable disease, particularly chicken pox, measles or mumps 1-3 weeks prior to camp, please contact us as soon as possible.



THIS PAGE TO BE COMPLETED BY PHYSICIAN OR PNP
Physician/PNP Recommendations and Restrictions at Camp



I examined _____ on _____.
camper's full name date of most recent examination

Weight _____ Height _____ BP _____

Current physical and medical condition:

Current Treatments:

Any medically-prescribed meal plan or dietary restrictions: _____

Description of any limitation, concern or restriction on camp activities:

I hereby verify that the information on the above form and preceding forms concerning health matters and medications is correct. In my opinion, this child is able to participate in Camp Weekaneatit Summer Camp.

Signature of Physician/Practitioner _____

Print Name _____ *Date* _____

Phone: _____

FOR CAMP MEDICAL STAFF SCREENING USE ONLY

FORM REVIEWED BY: _____

DATE: _____

UPDATES TO HEALTH HISTORY NOTED: YES NO NONE

ADDITIONAL COMMENTS: _____

MEDICATIONS RECEIVED:
